

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11426

11460

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Rural				c. LENGTH OF STAY IN 1b 17 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle C. Last Bauer				4. DATE OF DEATH Month Oct. Day 31 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 16, 1892		9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Proprietor		11. BIRTHPLACE (State or foreign country) Baltimore, Md.,		12. CITIZEN OF WHAT COUNTRY? U.S.A.,	
13. FATHER'S NAME Frank Bauer				14. MOTHER'S MAIDEN NAME Anna Grace			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 212 03-9355		17. INFORMANT Augusta E. Bauer, Aberdeen, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Occlusion (c) Coronary Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH Terminal Terminal 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 1-21-1959 to 10-31-1959 , that I last saw the deceased alive on 10-31-1959 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert P. Rodman				ADDRESS (Street, city or town, state) 8 Low St - Aberdeen, Md.			
PHYSICIAN'S NAME (Type) Robert P. Rodman				DATE SIGNED 11-3-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 4, 1959		22c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran		22d. LOCATION (City, town, or county) (State) Joppa, Harford, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard R. McEwen				ADDRESS Abingdon, Maryland		24a. REC'D BY REGISTRAR NOV 5 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11444

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11427

Item 7 Film G250 10/22/59 iwk

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford County</u> <u>Harford DOA Hospital</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Xxxxxx Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace, Maryland</u> DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Worton</u> 14X-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Haywood</u> Middle <u>Brown</u> Last		4. DATE OF DEATH Month <u>October</u> Day <u>11</u> Year <u>1959</u> 19	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Age 27</u> <u>Apr. 20, 1932</u>
9. AGE (In years last birthday) <u>26</u> yrs.		IF UNDER 1 YEAR Months <u>26</u> Days <u>26</u> Hours <u>26</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Various</u>	
11. BIRTHPLACE (State or foreign country) <u>Kent CO. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Oscar Brown</u>		14. MOTHER'S MAIDEN NAME <u>Helen Ford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>Korean</u>		16. SOCIAL SECURITY NO. <u>220-26-9093</u>	
17. INFORMANT <u>Marie Wilmer</u>		Address <u>RFD Worton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>fracture skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>auto accident auto object type</u>	
20c. TIME OF INJURY Month, Day, Year <u>6:00 PM 10-11-59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 40</u>		20f. (City or town) (County) (State) <u>Havre de Grace, Harford Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C. Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C. Palmer, M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10-12-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/15/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Coleman's Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>RFD Worton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. W. W.</u>		ADDRESS <u>Chestertown, Md.</u>	
24a. REC'D BY REGISTRAR <u>OCT 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

11461
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Bel Air</u>				c. LENGTH OF STAY IN 1b <u>35 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Allibone Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>L.</u> Last <u>Burkins</u>				4. DATE OF DEATH Month <u>October</u> Day <u>14</u> Year <u>19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 6, 1874</u>	9. AGE (In years lost birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Charles M. Burkins</u>				14. MOTHER'S MAIDEN NAME <u>Olevia Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mrs. Olevia Kohler, Rt. # 2, Street, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>153.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Initial lesion: Carcinoma of Cecum</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour <u>a. n.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Forest Hill, Md.</u>	
21. I certify that I attended the deceased from <u>March 28</u> , 19 <u>37</u> , to <u>October 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct. 13</u> , 19 <u>59</u> , and that death occurred at <u>7:20 PM</u> , from the causes and on the date stated above.							20f. (City or town) (County) (State)
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D.				DATE SIGNED <u>Oct. 15, 1959</u>			
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/17/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Deer Creek Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Forest Hill, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneale</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11429

Reg. Dist. No.

11462

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Harford</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Joppa</i>			c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>25 Route 40</i>			d. STREET ADDRESS <i>1095 Gilmore St</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Fred</i> First <i>Smith</i> Middle <i>Clark</i> Last			4. DATE OF DEATH <i>October 20</i> 19 <i>57</i> Month Day Year		
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-27-12</i>	9. AGE (In years last birthday) <i>47</i> yrs.	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Welder</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Md. Dry Dock.</i>	11. BIRTHPLACE (State or foreign country) <i>Va.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Oliver Clark</i>			14. MOTHER'S MAIDEN NAME <i>Bell</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. <i>234-01-7058</i>	17. INFORMANT <i>Mrs Ethel Clark, 109 S. Gilmore St.</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Evisceration brain</i> 816X DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Fracture arms, legs, spine,</i> (c) <i>ribs, skull</i> DUE TO cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident, auto - auto type</i>		
20c. TIME OF INJURY Month, Day, Year <i>11 30 a.m. 10-20 59</i>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>25 Route 40</i>	20f. (City or town) <i>Joppa</i> (County) <i>Harford</i> (State) <i>Md.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Gerald C Palmer</i>			M.D. CHIEF MEDICAL EXAMINER <i>Bell Air, Md.</i> DATE SIGNED <i>10-21-59</i>		
EXAMINER'S NAME (Type) <i>Gerald C Palmer</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/23/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. Peters Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Witzke Funeral Dir.</i> ADDRESS <i>4101 Edmondson Ave.</i>			24a. REC'D BY REGISTRAR <i>DATE OCT 23 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Harris</i>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]	
AGE [Illegible]		RACE [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
PLACE OF DEATH [Illegible]		CITY [Illegible]	
COUNTY [Illegible]		STATE [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]	
MANNER OF DEATH [Illegible]		MEDICAL HISTORY [Illegible]	
PRESENT ILLNESS [Illegible]		TREATMENT [Illegible]	
SIGNATURE OF EXAMINER [Illegible]		SIGNATURE OF WITNESS [Illegible]	
DATE [Illegible]		TIME [Illegible]	

11000 TOWNSEND AVE. BALTIMORE, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11430

11445

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE MD b. COUNTY CECIL ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE		c. LENGTH OF STAY IN 1b 7 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CONOWINGO 07X-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital				d. STREET ADDRESS —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle NICHOLAS Last Fowler				4. DATE OF DEATH Month Oct Day 31 Year 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT-31-1954		9. AGE (In years last birthday) 30 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARTENDER		10b. KIND OF BUSINESS OR INDUSTRY TAVERN		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES N. FOWLER SR.				14. MOTHER'S MAIDEN NAME MARY BEHE HASH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT M. J. N. FOWLER SR. DARLINGTON, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis 981X DUE TO Gunshot Wound of Abdomen Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gunshot Wound of Abdomen DUE TO (c) Gunshot Wound of Abdomen							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) HARFORD		(County) MD.	(State) MD.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE William V. Goudy				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William V. Goudy				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-3-1959		22c. NAME OF CEMETERY OR CREMATORY MT ZION Cem.		22d. LOCATION (City, town, or county) HARFORD MD.	
23. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell				24a. REC'D BY REGISTRAR Nov 4 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kenna	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

James N. Foster
Foster Memorial Hospital

22 31 22

Testis
wound of abdomen

William H. Foster

1-24-22

x x x

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11431

11446

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11 East Bel Air Avenue		d. STREET ADDRESS 11 East Bel Air Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First THOMAS Middle JOSEPH Last GEBHART		4. DATE OF DEATH Month October Day 9 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1939
9. AGE (In years last birthday) 20 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas F. Gebhart		14. MOTHER'S MAIDEN NAME Ruth C. Boulden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-34-6291	
17. INFORMANT Thomas F. Gebhart, Aberdeen, Md.		Address 11 E. Bel Air.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Hemorrhage. DUE TO (c) Leukemia - Hodgkins Disease		INTERVAL BETWEEN ONSET AND DEATH 1 HOUR 2 days - 5 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 50 , to Oct 9 , 19 59 , that I last saw the deceased alive on October 9 , 19 59 , and that death occurred at 5:10 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 200 N. Union Avenue 10/10/59			
ACTUAL SIGNATURE Frank Wolbert M.D. M.D.		200 N. Union Avenue 10/10/59	
PHYSICIAN'S NAME (Type) Frank Wolbert, M.D.		Havre de Grace, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/12/59	
22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens, Bel Air, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John E. Tarrueg		24a. REC'D BY REGISTRAR DATE OCT 14 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

CERTIFICATE OF DEATH

1948

Form 100-100

DATE OF DEATH

Place of Death

Age

Sex

Occupation

Place of Birth

Place of Birth

Married

Spouse

Spouse

Cause of Death

Cause of Death

Signature

Physician

Physician

Date

Date

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11432

MEDICAL CERTIFICATION

VS. A15ME(5)
5M 9/55

1. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Name]		SEX [Male/Female]		AGE [Age]	
DATE OF DEATH [Date]		PLACE OF DEATH [Place]		TIME OF DEATH [Time]	
OCCUPATION [Occupation]		CAUSE OF DEATH [Cause]		MANNER OF DEATH [Manner]	
SIGNATURE OF MEDICAL EXAMINER [Signature]		SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]	
ADDRESS OF DECEASED [Address]		ADDRESS OF MEDICAL EXAMINER [Address]		ADDRESS OF WITNESS [Address]	
CITY [City]		COUNTY [County]		STATE [State]	
ZIP CODE [ZIP Code]		MEDICAL EXAMINER'S LICENSE NO. [License No.]		WITNESS'S LICENSE NO. [License No.]	
MEDICAL EXAMINER'S CERTIFICATE NO. [Certificate No.]		WITNESS'S CERTIFICATE NO. [Certificate No.]		DECEASED'S CERTIFICATE NO. [Certificate No.]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11433

11448

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b 31	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		d. STREET ADDRESS 28 Church Green	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 28 Church Green		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH WATSON GIFFORD		4. DATE OF DEATH Month Day Year October 18 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 11, 1879
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book-keeper, Ret. Hotel		10b. KIND OF BUSINESS OR INDUSTRY Hotel	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Watson Gifford		14. MOTHER'S MAIDEN NAME Elizabeth McCullough	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 181-22-4513-A	
17. INFORMANT Elizabeth Hodgson, Oxford, Penna.		Address 51 N. 3rd. St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) Heart Failure Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH Terminal 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 17, 1959 , to October 18, 1959 , that I last saw the deceased alive on October 17, 1959 , and that death occurred at 8:00 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 8 Law Street 10-19-59	
ACTUAL SIGNATURE Peter P. Rodman		M.D. Peter P. Rodman	
PHYSICIAN'S NAME (Type) Peter P. Rodman, M.D.		Aberdeen, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/21/59	
22c. NAME OF CEMETERY OR CREMATORY West Nottingham Cem.		22d. LOCATION (City, town, or county) (State) Cecil County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Barron		Tarring Funeral Home Aberdeen, Md.	
24a. REC'D BY REGISTRAR DATE OCT 22 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

CERTIFICATE OF DEATH

DECEASED		DATE OF DEATH	
JAMES M. WATSON		JAN. 11, 1934	
AGE		SEX	
65		M	
RACE		PLACE OF BIRTH	
W		MD	
MARRIED		OCCUPATION	
Y		DRIVER	
CAUSE OF DEATH		PLACE OF DEATH	
HEART DISEASE		HOME	
MANNER OF DEATH		CERTIFICATE NO.	
NATURAL		12345	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. M. WATSON		J. M. WATSON	
DATE		DATE	
JAN. 11, 1934		JAN. 11, 1934	

DECEASED

DATE OF DEATH

AGE

SEX

RACE

PLACE OF BIRTH

MARRIED

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

SIGNATURE OF PHYSICIAN

SIGNATURE OF REGISTRAR

DATE

DATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11449 CERTIFICATE OF DEATH

Reg. Dist. No.

11434

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u> c. LENGTH OF STAY IN 1b <u>41 DAYS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u> d. STREET ADDRESS <u>51 Granite Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GARY</u> Middle <u>GRiffin</u> Last <u>GRiffin</u>		4. DATE OF DEATH Month <u>October</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/11/59</u>
9. AGE (In years last birthday) <u>-</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>4</u>	11. IF UNDER 24 HRS. Hours <u>10</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elmer Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Joyce Marie Griffin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. ADDRESS <u>Port Deposit</u>		18. ADDRESS <u>Lenabel Griffin, 51 Granite Ave. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>571.0</u> DUE TO <u>BRONCHO PNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Gastro-enteritis</u> (c) <u>HISTIO-ENTERITIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pyelitis - Cystitis + Nephritis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-1-59</u> to <u>10-11-59</u> , that I last saw the deceased alive on <u>10-10-59</u> , and that death occurred at <u>5:45 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>House Staff</u> DATE SIGNED <u>10-11-59</u>	
ACTUAL SIGNATURE <u>L. J. McLean</u>		M.D. <u>House Staff</u>	
PHYSICIAN'S NAME (Type) <u>L. J. McLean</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-12-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zoar</u>		22d. LOCATION (City, town, or county) (State) <u>Conowingo, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. Patterson & Son</u>		ADDRESS <u>Perryville, Md.</u>	
24a. REC'D BY REGISTRAR <u>OCT 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Thomas</u>	

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11463

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b X Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US ARMY HOSPITAL ABERDEEN PROVING GROUND, MARYLAND		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KAREN Middle MARIE Last HABERER		4. DATE OF DEATH Month October Day 17 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 17, 1959
9. AGE (In years last birthday) yrs. 35		10. IF UNDER 1 YEAR Months Days Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jerry Francis Haberer		14. MOTHER'S MAIDEN NAME Phyllis JoAnn Crook	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N/A		16. SOCIAL SECURITY NO. None	
17. INFORMANT Father		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) An encephaly 750X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 55 MIN.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10 Oct 14 15 , 19 59 , to 17 Oct 14 50 , 19 59 , that I last saw the deceased alive on 17 Oct 14 50 , 19 59 , and that death occurred at 12:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Hans A. Keuls		DATE SIGNED 17 Oct '59	
PHYSICIAN'S NAME (Type) HANS A KEULS Capt MC		M.D. USAH - APC	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/20/1959	
22c. NAME OF CEMETERY OR CREMATORY Post Cemetery		22d. LOCATION (City, town, or county) (State) Aberdeen Proving Ground	
23. FUNERAL DIRECTOR'S SIGNATURE John E. Barriag		ADDRESS Aberdeen road	
24a. REC'D BY REGISTRAR OCT 23 '59		24b. REGISTRAR'S SIGNATURE Carlton S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11663

Name of Deceased: John Doe
 Date of Birth: 10/15/1920
 Sex: Male
 Race: White
 Date of Death: 10/25/1990
 Place of Death: Home
 Cause of Death: Heart Disease
 Physician: Dr. Smith
 Burial Place: Cemetery
 Registrar: John Doe
 Date: 10/26/1990
 Signature: [Signature]
 Title: Registrar

DEATH NO.

DATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11436

11464

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Hall		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Hall	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Norrisville Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jacob Willard Hammond		4. DATE OF DEATH Month October Day 1 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1888
9. AGE (In years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214.05.3954	
17. INFORMANT John W. Hammond		Address 2108 Lukewood Ave. 7	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chr. passive congestion of lung 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic myocarditis + sec. anemia DUE TO (c) Chronic myelogenous leukemia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 days Prob. 1 1/2 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 15, 1959 , to Oct. 1, 1959 , that I last saw the deceased alive on Sept. 30, 1959 , and that death occurred at 4:50 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Norman H. Gemmill		DATE SIGNED Oct. 1, 1959	
PHYSICIAN'S NAME (Type) Norman H. Gemmill		ADDRESS (Street, city or town, state) Stewartstown, Pa.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 5, 1959	22c. NAME OF CEMETERY OR CREMATORY Baltimore	22d. LOCATION (City, town, or county) (State) Baltimore Ma
23. FUNERAL DIRECTOR'S SIGNATURE John T. Stansbury		24a. REC'D BY REGISTRAR OCT 6 '59	
ADDRESS 6411 Windsor Mill Rd.		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the pages are necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

Item 18 Film 253 12-7-59 MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11450 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11437											
1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY Harford					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harre de Grace						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) JOPPA					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital						d. STREET ADDRESS					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) VERNON			First Middle Last			4. DATE OF DEATH October 30			Month Day Year 1959		
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 17, 1924		9. AGE (In years last birthday) 34 12 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman				10b. KIND OF BUSINESS OR INDUSTRY Railroad				11. BIRTHPLACE (State or foreign country) Harford Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.,	
13. FATHER'S NAME William F. Harris						14. MOTHER'S MAIDEN NAME Lillie Morris					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II				16. SOCIAL SECURITY NO. 218 12-2627		17. INFORMANT Bernice E. Harris, Joppa, Maryland.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 10/30/59 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE W. Bradley King, Jr. M.D. EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D. Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Nov. 2, 1959		22c. NAME OF CEMETERY OR CREMATORY John Wesley		22d. LOCATION (City, town, or country) (State) Abingdon, Harford, Maryland.			
23. FUNERAL DIRECTOR Howard K. Mc Comas & Son						ADDRESS Abingdon, Maryland.		24a. REC'D BY REGISTRAR NOV 4 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

NOV 1930

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HARRISON

HARRISON

HARRISON, William F.

October 30

HARRISON

HARRISON

1930

Nov. 1, 1930

Colored

Male

U.S.A.

HARRISON, W. F.

HARRISON

HARRISON

HARRISON

HARRISON

481 67 Harrison, W. F., U.S.A.

Yes

X

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HARRISON, W. F.

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HARRISON, W. F.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11465

CERTIFICATE OF DEATH

Reg. Dist. No.

11438

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pylesville		c. LENGTH OF STAY IN 1b 22 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eck Middle Louisville Last Hash		4. DATE OF DEATH Month October Day 12 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1877
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Fox, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas B. Hash		14. MOTHER'S MAIDEN NAME Melinda Brewer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 199-07-8318	
17. INFORMANT Mary B. Hash, Pylesville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteria sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic myocarditis. Hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept , 19 50 , to Oct 11 , 19 59 , that I last saw the deceased alive on Oct 10 , 19 59 , and that death occurred at 3 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Edward W. Henson M.D.		Haun Grove, Pa Oct 12, 1959	
PHYSICIAN'S NAME (Type) Edward W. Henson		Haun Grove, Pa	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 14, 1959	
22c. NAME OF CEMETERY OR CREMATORY Oak Grove		22d. LOCATION (City, town, or county) (State) Belair, Harford Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Harkins		ADDRESS Delta, Penna.	
24a. REC'D BY REGISTRAR OCT 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Henson	

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11439

Item 4 Film G252 11/20/59 iwk

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harrode Grace Lifetime</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harrode Grace</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>335 Strawberry</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Mamie</i> Last <i>Holmes</i>		4. DATE OF DEATH Month <i>Oct</i> Day <i>23</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 12, 1876</i>
9. AGE (In years last birthday) <i>83</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic Worker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Private Family</i>	
11. BIRTHPLACE (State or foreign country) <i>Harrode Grace, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>George Weeks</i>		14. MOTHER'S MAIDEN NAME <i>Harriett Haycock</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Mrs. Leona Royter, Harrode, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO <i>420.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>arteriosclerotic heart disease</i> DUE TO <i>generalized arteriosclerosis</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct 22, 1959</i> to <i>Oct 23, 1959</i> , that I last saw the deceased alive on <i>Oct 23, 1959</i> , and that death occurred at <i>7:00 P. M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wm. H. Wachsmuth</i>		ADDRESS (Street, city or town, state) <i>407 S. Union Ave Harrode Grace, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Wm. H. Wachsmuth</i>		DATE SIGNED <i>10/26/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Oct. 27, 1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. James Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Harrode Grace, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Esther J. Bullock</i>		ADDRESS <i>Harrode Grace, Md.</i>	
24a. REC'D BY REGISTRAR <i>Oct 29 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Wm. H. Wachsmuth</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11452 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11440

1. PLACE OF DEATH a. COUNTY <u>Harford County</u> <u>Dorchester Hospital</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Kent</u> <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrods Creek</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Worton</u> <u>Kent County</u> <u>14X-2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>RD 1</u>			
3. NAME OF DECEASED (Type or print) First <u>Engine</u> Middle <u>Enoch</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>October</u> Day <u>11</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>E</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-21-33</u>	9. AGE (In years last birthday) <u>26</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>Kent CO. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Reuben Jones</u>				14. MOTHER'S MAIDEN NAME <u>Addie Wilson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>220-28-2203</u>		17. INFORMANT <u>Addie Jones RFD Worton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> <u>819X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>A no accident, auto-object type</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>6</u> <u>pm</u> <u>Oct 11 1959</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 48</u>		20f. (City or town) (County) (State) <u>Harrods Creek Harford md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md</u> DATE SIGNED <u>10-11-59</u>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Coleman's Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>RFD Worton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. Day</u>				ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 16 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>			

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11466

CERTIFICATE OF DEATH

Reg. Dist. No. 11441

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. LENGTH OF STAY IN 1b <u>20 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rural #1 - near Paradise Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>J.</u> Last <u>Kelly</u>		4. DATE OF DEATH Month <u>10</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 10 1894</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber Industry</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Kelly</u>		14. MOTHER'S MAIDEN NAME <u>Margie Banks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>War #1</u>		16. SOCIAL SECURITY NO. <u>220-03-1007</u>	
17. INFORMANT Address <u>Hattie T. Kelly - Aberdeen #1 - Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-VASCULAR COLLAPSE</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA OF STOMACH</u> DUE TO (c) <u>UNKNOWN</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-24</u> , 19 <u>59</u> , to <u>10-28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-24</u> , 19 <u>59</u> , and that death occurred at <u>1:00 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Berntha D. Hirsch</u> M.D.		ADDRESS (Street, city or town, state) <u>421 CONGRESS AVE.</u> DATE SIGNED <u>10/29/59</u>	
PHYSICIAN'S NAME (Type) <u>DR. G. D. HIRSCH</u>		<u>HAURE de GRACE MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/31/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen R. 1 - Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Tarrington</u> ADDRESS <u>Aberdeen, Maryland</u>		24a. REC'D BY REGISTRAR <u>NOV 3 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11467 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY Harford
CITY (If outside corporate limits, write RURAL
OR and give nearest town)
TOWN Rural, Bel Air

MARYLAND

LENGTH OF STAY
(in this place)
Entire lifeHOSPITAL OR
INSTITUTION OR
STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Harford

CITY (If outside corporate limits, write RURAL and give nearest town)

OR
TOWN Rural, Bel AirSTREET
ADDRESS (If rural give location)
/3. NAME OF
DECEASED
(Type or Print)

(First)

(Middle)

(Last)

JosephMiltonKelly4. DATE
OF
DEATH

(Month)

(Day)

(Year)

October 2919 59

5. SEX

Male6. COLOR OR
RACEWhite7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)Married

8. DATE OF BIRTH

January 28, 1896

9. AGE last birthday

63 yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)Farmer10b. KIND OF BUSINESS
OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland12. CITIZEN OF WHAT
COUNTRY?U.S.A.

13. FATHER'S NAME

James M. Kelly

14. MOTHER'S MAIDEN NAME

Annie Glackin15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

218-18-1852

17. INFORMANT & ADDRESS

Mrs. Marion Kelly, Forest Hill, Md.

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

18. MEDICAL CERTIFICATION

IMMEDIATE CAUSE (A)

443XCerebral Hemorrhage

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.(B) Chr. hypertensive cardiovascular disease

DUE TO

(C)

11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.Three previous episodes of cerebral thrombosisINTERVAL BETWEEN
ONSET AND DEATHSudden death15 yrs1st 9 yrs ago

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED

White ☐ Not white ☐
at work at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 17, 1959, to Oct. 29, 1959, that I last saw the deceased
alive on Sept. 25, 1959, and that death occurred at 6:45 A.M. from the causes and on the date stated above.

SIGNATURE

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)Burial

DATE THEREOF

Oct. 31, 1959

NAME OF CEMETERY OR CREMATORY

St. Ignatius

LOCATION (City, town, or county)

Rt. #1, Bel Air, Md.

(State)

24. REC'D BY REGISTRAR

DATE NOV 2 '59

REGISTRAR'S SIGNATURE

Arthur L. Kraus

25. FUNERAL DIRECTOR'S SIGNATURE

Joseph J. Tosti, Bel Air, Md.

ADDRESS

INSTRUCTIONS

1. TO ATTEND PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

DEATH CERTIFICATE

Reg. Dist. No.

A. DEATH OCCURRED AT HOME OF DECEASED

NAME OF DECEASED
HAROLD
AGE
SEX
RACE
BIRTH DATE

RESIDENCE
Baltimore, Md.

DECEASED'S ADDRESS
Baltimore, Md.

DATE OF DEATH
JANUARY 28, 1933

TIME OF DEATH
10:30 AM

CAUSE OF DEATH
Pneumonia

PLACE OF DEATH
Home

DATE OF BURIAL
JANUARY 30, 1933

PLACE OF BURIAL
Baltimore, Md.

DATE OF REGISTRATION
JANUARY 30, 1933

PLACE OF REGISTRATION
Baltimore, Md.

REGISTERED

1

INSTRUCTIONS

TO ATTEND PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11443

11468 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bel Air Rural</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bel Air</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>Thomas Run Road</u>			
3. NAME OF DECEASED (Type or Print) <u>Thomas</u> <u>Nice</u> <u>Livezey Jr.</u>				4. DATE OF DEATH (Month) <u>10</u> (Day) <u>18</u> (Year) <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>11-25-1880</u>		9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Nice Livezey Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Sylvania Stewart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>218-26-7100</u>		17. INFORMANT & ADDRESS <u>Miss Margaret Livezey</u> <u>Bel Air Rd 13, #325 Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443X IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Hypertensive C-V-D</u>				<u>20 YEARS</u>			
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. _____ at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/18/1950</u>, to <u>10/18/1959</u>, that I last saw the deceased alive on <u>10/18/1959</u>, and that death occurred at <u>3:45 PM</u>, from the causes and on the date stated above.							
SIGNATURE <u>Robert Barthel</u> M.D.				DATE SIGNED <u>10-19-59</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-21-59</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>		LOCATION (City, town, or county) (State) <u>Bel Air, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur L. Kears</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T. Felt</u> ADDRESS <u>Bel Air Md</u>			
DATE <u>OCT 21 '59</u>							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 5, 12 Film G250 10-16-59 et

CERTIFICATE OF DEATH

11444

11469

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford Co: Maryland MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford County			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fallston, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fallston, Maryland			
c. LENGTH OF STAY IN 1b About 3 Wk.							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fallston, Maryland				d. STREET ADDRESS Fallston Watervale Road,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle SUSAN Last LUCHANSKY				4. DATE OF DEATH Month OCT Day 7 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 15, 1895	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 11 Days 22		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Austria	
12. CITIZEN OF WHAT COUNTRY? No Austria							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Paul Luchansky-Fallston Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY FAILURE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO-SCLEROTIC CARDIO-VASCULAR DIS. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
INTERVAL BETWEEN ONSET AND DEATH LESS THAN 6 HRS 2 YRS							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	
20f. (City or town) 				20g. (County) 			
20h. (State) 							
21. I certify that I attended the deceased from 19 SEPT , 19 59 , to 7 OCT , 19 59 , that I last saw the deceased alive on 19 Sept , 19 59 , and that death occurred at 6 A. M., from the causes and on the date stated above. ACTUAL SIGNATURE H.P. Sidwell M.D. ADDRESS (Street, city or town, state) 401 Franklin St. BALTIMORE DATE SIGNED 10 OCT 59 PHYSICIAN'S NAME (Type) H.P. SIDWELL M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-12-1959		22c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery		22d. LOCATION (City, town, or county) (State) Jessup, Lackawanna Co: Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE George J. Ruth, Inc. - 1735 Harford Avenue Baltimore, Maryland				24a. REC'D BY REGISTRAR DATE OCT 9 '59		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11553

NAME OF DECEASED Lillian, Maryland		MARRIAGE Lillian, Maryland	
PLACE OF BIRTH Lillian, Maryland		PLACE OF BIRTH Lillian, Maryland	
DATE OF BIRTH 11 22 1893		DATE OF BIRTH 11 22 1893	
SEX Female		SEX Female	
RACE White		RACE White	
OCCUPATION Unknown		OCCUPATION Unknown	
PLACE OF DEATH Baltimore, Maryland		PLACE OF DEATH Baltimore, Maryland	
DATE OF DEATH 11 22 1933		DATE OF DEATH 11 22 1933	
TIME OF DEATH 11 22 1933		TIME OF DEATH 11 22 1933	
CAUSE OF DEATH Unknown		CAUSE OF DEATH Unknown	
MANNER OF DEATH Natural		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN Lillian, Maryland		SIGNATURE OF PHYSICIAN Lillian, Maryland	
SIGNATURE OF WITNESS Lillian, Maryland		SIGNATURE OF WITNESS Lillian, Maryland	
SIGNATURE OF DECEASED Lillian, Maryland		SIGNATURE OF DECEASED Lillian, Maryland	
SIGNATURE OF NEXT OF KIN Lillian, Maryland		SIGNATURE OF NEXT OF KIN Lillian, Maryland	
SIGNATURE OF BURIAL OFFICER Lillian, Maryland		SIGNATURE OF BURIAL OFFICER Lillian, Maryland	
SIGNATURE OF REGISTRAR Lillian, Maryland		SIGNATURE OF REGISTRAR Lillian, Maryland	

RECEIVED
 BALTIMORE, MD.
 NOV 22 1933
 DEPARTMENT OF HEALTH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any person is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11470 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11445

Item 3 Film G250 10-26-59 et

1. PLACE OF DEATH a. COUNTY H arford b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood c. LENGTH OF STAY IN 1b 14 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5 Morgan Court				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md. b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood 5 Morgan Court d. STREET ADDRESS 5 Morgan Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle A. Last Matherly				4. DATE OF DEATH Month Oct. Day 17, Year 19 59			
5. SEX M		6. COLOR OR RACE Wh		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 6, 1915	
9. AGE (In years birth day) 44 yrs.		IF UNDER 1 YEAR Months 44 Days 44		IF UNDER 24 HRS. Hours 44 Min. 44			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Dairy		11. BIRTHPLACE (State or foreign country) Bristol, Tenn.,	
12. CITIZEN OF WHAT COUNTRY? U.S.A.,							
13. FATHER'S NAME John D. Matherly				14. MOTHER'S MAIDEN NAME Clara P. Pennington			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give year or dates of service) WW II				16. SOCIAL SECURITY NO. 222-05-0043		17. INFORMANT Address Mrs., Nora Matherly, Edgewood, Maryland.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) } (a), stating the underlying cause last. (c) } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY = Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE W. Bradley King, Jr.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				DATE SIGNED 10/18/59			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 20, 1959		22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		22d. LOCATION (City, town, or country) (State) Bel Air, Harford, Maryland.	
23. FUNERAL DIRECTOR Howard K. McCombs Jr.				ADDRESS Abingdon, Md.,			
24a. REC'D BY REGISTRAR Oct 21 '59				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

11170
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed in 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11446

11453

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>HAVRE DE GRACE</u>		LENGTH OF STAY (In this place) <u>18 MOS.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>HAVRE DE GRACE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>314 LAFAYETTE ST.</u>				STREET ADDRESS (If rural give location) <u>314 LAFAYETTE ST</u>			
3. NAME OF DECEASED (Type or Print) <u>EDWARD L</u> (First) <u>McFARLAND</u> (Last)				4. DATE OF DEATH (Month) <u>OCT</u> (Day) <u>22</u> (Year) <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>APR. 5, 1874</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NIGHT WATCHMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>ROBERT N. McFARLAND</u>				14. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH MILLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-26-0560</u>		17. INFORMANT & ADDRESS <u>MR. SHIRLEY W. McFARLAND</u> <u>314 LAFAYETTE ST. HAVRE DE GRACE, MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
332X IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>14g</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>OCT 19</u>, 19 <u>29</u>, to <u>Oct 22</u>, 19 <u>59</u>, that I last saw the deceased alive on <u>Oct 22</u>, 19 <u>59</u>, and that death occurred at <u>7 A</u>.M, from the causes and on the date stated above.							
SIGNATURE <u>Wm. H. Walshaw</u>		ADDRESS (Street, city, town, state) <u>4075 Union Ave</u>		DATE SIGNED <u>10/23/59</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>OCT 25 1959</u>		NAME OF CEMETERY OR CREMATORY <u>Rileyville Cem.</u>		LOCATION (City, town, or county) (State) <u>Page Co. Va</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>K. Madison Mitchell</u>		ADDRESS <u>HAVRE DE GRACE MD.</u>	
DATE <u>OCT 28 '59</u>							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11447

11454

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Cal ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit 07X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial				d. STREET ADDRESS 252 N. Main St.			
3. NAME OF DECEASED (Type or print) John Wesley McMullen				4. DATE OF DEATH October 8 1959			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 8, 1879	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Day		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME William McMullen				14. MOTHER'S MAIDEN NAME Clara Warfield			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT C.S. McMullen, 3203 Elgin Ave., Balto. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 10 min > 10 min							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/5/59 to 10/8/59 , that I last saw the deceased alive on 10-8-59 , and that death occurred at 11:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE B. J. Plunkett Jr. M.D.				ADDRESS (Street, city or town, state) 10-8-59 DATE SIGNED			
PHYSICIAN'S NAME (Type) B. J. Plunkett Jr.				Havre de Grace, Md			
22a. BURIAL, CREMATION, REMAINS (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		10-12-1959		Jones Memorial Cem.		Port Deposit, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Leea. Patterson & Son ADDRESS Perryville, Md.				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE OCT 13 59			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11054

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 45		4. RACE White		5. DATE OF DEATH Jan 10, 1910		6. PLACE OF DEATH Home	
7. OCCUPATION Carpenter		8. MARITAL STATUS Married		9. PLACE OF BIRTH Maryland		10. DATE OF BIRTH Jan 10, 1865		11. PLACE OF BIRTH Baltimore		12. CAUSE OF DEATH Heart Disease	
13. DISEASE OR INJURY Heart Disease		14. PERIOD OF ILLNESS 2 weeks		15. TIME OF DEATH 10:00 AM		16. SIGNATURE OF PHYSICIAN J. H. Harris		17. SIGNATURE OF WITNESSES J. H. Harris		18. SIGNATURE OF REGISTRAR J. H. Harris	
19. PLACE OF INTERMENT Catholic Cemetery		20. NAME OF CLERGYMAN Rev. J. H. Harris		21. NAME OF FUNERAL HOME J. H. Harris		22. NAME OF UNDERTAKER J. H. Harris		23. NAME OF CEMETERY Catholic Cemetery		24. NAME OF BURIAL PLACE J. H. Harris	

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY THE REGISTRAR OF THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u>				c. LENGTH OF STAY IN 1b <u>19 yrs.,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Emmorton Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>F.</u> Last <u>MYERS</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>8</u> Year <u>19 59</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 8, 1892</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home Construction</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>							
13. FATHER'S NAME <u>L. B. Myers</u>				14. MOTHER'S MAIDEN NAME <u>Camelia Huey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>242-01-7693</u>		17. INFORMANT <u>L.E. Myers,</u>		Address <u>Jonesville, N.C.,</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Acute MYOCARDIAL INFARCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>CORONARY THROMBOSIS</u> (c) <u>ARTERIO SCLEROTIC HEART Dis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>N/A</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Approx. 2 hrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>N/A</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 8</u> , 19 <u>59</u> , to <u>Oct 8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 8, 1959</u> , 19 <u>59</u> , and that death occurred at <u>4:50 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Warren R. Lesch MD</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>115 Fulford Bel Air, MD 12/8/59</u>			
PHYSICIAN'S NAME (Type) <u>Warren R. Lesch</u>				<u>115 Fulford Bel Air, Md.,</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Oct. 9, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Reins-Sturdivant F.H.,</u>		22d. LOCATION (City, town, or county) (State) <u>North Wilkesboro, Wilkes, N.C.,</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. McCombs Jr</u>				ADDRESS <u>Abingdon, Maryland.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 13 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carlton E. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 14 Film 6251 11-13-59 et

11472

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

CERTIFICATE OF DEATH

11449

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle GEORGE Last PLUMMER		4. DATE OF DEATH Month October Day 31 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 Feb. 1882
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min. 77	11. IF UNDER 24 HRS. Months 77 Days 77 Hours 77 Min. 77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter (Ret)		10b. KIND OF BUSINESS OR INDUSTRY Self employed	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Plummer		14. MOTHER'S MAIDEN NAME Sarah Parks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-12-8705	
17. INFORMANT Albert Plummer, Forest Hill, Maryland Rd.		Address Chestnut Hill	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) Disease		INTERVAL BETWEEN ONSET AND DEATH 1 day 4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 15th 1958 to Oct. 31st 1959 , that I last saw the deceased alive on Oct. 31st 1959 , and that death occurred at 12:30 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward C. Loo		ADDRESS (Street, city or town, state) DATE SIGNED 211 N. Union Avenue 11/2/59	
PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.		Havre de Grace, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/3/1959	22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery	22d. LOCATION (City, town, or county) (State) Belters R. T. Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John E. Tarring		24. REC'D BY REGISTRAR NOV 5 '59	
ADDRESS Tarring Funeral Home Aberdeen, Md.		24b. REGISTRAR'S SIGNATURE Arthur E. Tarring	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
CERTIFICATE OF DEATH

1917

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
Jan 15, 1917		Home		Heart Disease	
Time of Death		Occupation		Usual Residence	
10:00 AM		Farmer		Home	
Manner of Death		Signature of Physician		Signature of Registrar	
Natural		[Signature]		[Signature]	
Burial Place		Name of Undertaker		Name of Funeral Home	
Cemetery		[Name]		[Name]	
Burial Date		Burial Time		Burial Place	
Jan 16, 1917		11:00 AM		Cemetery	
Name of Informant		Relationship		Signature of Informant	
John Doe		Son		[Signature]	
Address of Informant		Address of Deceased		Address of Registrar	
[Address]		[Address]		[Address]	
City		County		State	
Baltimore		Baltimore		Maryland	
Country		Signature of Registrar		Signature of Registrar	
USA		[Signature]		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11455

CERTIFICATE OF DEATH

Reg. Dist. No.

11450

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Pa. b. COUNTY YORK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVERDE GRACE		c. LENGTH OF STAY IN lb 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SAMUEL WALTER POMRANING First Middle Last		4. DATE OF DEATH October 17 1959 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-14-59
9. AGE (In years last birthday) 3 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME SAMUEL WALTER POMRANING		14. MOTHER'S MAIDEN NAME HELEN SCARBOROUGH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. WALTER POMRANING, DELTA, PA.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 750x DUE TO New Born Immaturity with microcephaly & acrania Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/16 , 19 59 , to 10/17 , 19 59 , that I last saw the deceased alive on 10/17 , 19 59 , and that death occurred at 9:05 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) HAVERDE GRACE, MD. DATE SIGNED 10/17/59			
ACTUAL SIGNATURE F. I. HATEM		M.D. HAVERDE GRACE, MD.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-18-59	
22c. NAME OF CEMETERY OR CREMATORY PINE GROVE		22d. LOCATION (City, town, or county) (State) DELTA, YORK, PA.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Haskins, Delta, Pa.		24a. REC'D BY REGISTRAR OC 20 '59 DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

1944

CONFIDENTIAL

1944

1944

ATLANTA, Georgia

October 10, 1944

October 10, 1944

P.O. Box 10

GA

James Watson

James Watson

James Watson

James Watson

James Watson

James Watson

James Watson

James Watson

James Watson

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11473

CERTIFICATE OF DEATH

11451

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Darlington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X (Rural) Darlington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D.		e. STREET ADDRESS R.F.D.	
3. NAME OF DECEASED (Type or print) First AGNES Middle VIOLA Last PRESTON		4. DATE OF DEATH Month October Day 21 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12, 1885
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Carty		14. MOTHER'S MAIDEN NAME Annie West	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. LeRoy Hasson, Darlington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X DUE TO Dissecting Aneurysm of Aorta Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterial Hypertension (c) 3 yr.		INTERVAL BETWEEN ONSET AND DEATH 45 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-30-59 , 19 59 , to 10-21- , 19 59 , that I lost saw the deceased alive on 10-21- , 19 59 , and that death occurred on 10:30AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8 Low St - Aberdeen, Md. DATE SIGNED			
ACTUAL SIGNATURE Peter P. Rodman		M.D. Aberdeen, Md.	
PHYSICIAN'S NAME (Type) Peter P. Rodman		M.D. Aberdeen, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/24/59	22c. NAME OF CEMETERY OR CREMATORY Rock Run Cemetery	22d. LOCATION (City, town, or county) (State) R.D. Havre de Grace, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John E. Tarring		24a. REC'D BY REGISTRAR Tarring Funeral Home	
ADDRESS Aberdeen, Md.		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
John Doe		Jan. 1, 1900	
Age		Sex	
45		Male	
Place of Birth		Cause of Death	
Baltimore, Md.		Heart Disease	
Occupation		Signature of Physician	
Teacher		J. B. Smith	
Residence		Signature of Registrar	
123 Main St.		W. H. Jones	
City		Date of Registration	
Baltimore		Jan. 5, 1900	
County		Signature of Coroner	
Baltimore		J. C. Brown	
State		Signature of Registrar	
Maryland		W. H. Jones	

CERTIFICATE OF DEATH

Reg. Dist. No. 11452

11456

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE				c. LENGTH OF STAY IN TB 10 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.				e. STREET ADDRESS Box 56			
3. NAME OF DECEASED (Type or print) First MARY Middle E. Last PRICE				4. DATE OF DEATH Month October Day 7 Year 1959			
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 18, 1889	9. AGE (In years last birthday) yrs. 70	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE M. HARDY				14. MOTHER'S MAIDEN NAME MARY E. NORRIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Richard Price, Edgewood, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic and Cerebrovascular 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) and Cardiovascular Disease. DUE TO (c) Congestive Heart Failure + Cerebral Thrombosis						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/28 , 19 59 , to 10/6 , 19 59 , that I last saw the deceased alive on 10/6 , 19 59 , and that death occurred at 5:50 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE E. Louis Kahan MD				ADDRESS (Street, city or town, state) Box 96 Edgewood, Md			
DATE SIGNED 10/8/59							
PHYSICIAN'S NAME (Type) E. Louis Kahan				Edgewood Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 10, 1959		22c. NAME OF CEMETERY OR CREMATORY Cokesbury Memorial		22d. LOCATION (City, town, or county) (State) Abingdon, Harford, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard E. McNamee				ADDRESS Abingdon Md		24a. REC'D BY REGISTRAR DATE OCT 13 '59	
				24b. REGISTRAR'S SIGNATURE Arthur E. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11474

CERTIFICATE OF DEATH

Reg. Dist. No. 11453

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Rocks</u>			c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Rocks</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bessie May Rutherford</u>				4. DATE OF DEATH Month Day Year <u>October 1, 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 8, 1889</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>3 26</u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Thomas Cook</u>				14. MOTHER'S MAIDEN NAME <u>Victoria Reedy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. ---		17. INFORMANT <u>John Rutherford</u>		Address <u>Rocks, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion, terminating</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <u>Chronic decompensated cardio-vascular disease</u>							INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>46</u> , to <u>Oct. 1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct. 1</u> , 19 <u>59</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Forest Hill, Md. Oct. 5, 1959</u>			
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/7/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Centre</u>		22d. LOCATION (City, town, or county) (State) <u>Forest Hill, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Kury</u>				ADDRESS <u>Jarrettsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 9 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Catharine E. Kury</u>			

may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11457

CERTIFICATE OF DEATH

11454

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air, Md.</u>				c. LENGTH OF STAY IN TB <u>3 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Convalescent Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Thomas Winfield Scarff</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>6</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 21, 1870</u>	9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>				13. FATHER'S NAME <u>Charles Tyler Scarff</u>			
14. MOTHER'S MAIDEN NAME <u>Martha R. Hitchcock</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-----</u>			
16. SOCIAL SECURITY NO. <u>-----</u>				17. INFORMANT <u>Mrs. Mark Hopkins, Bel Air, Md.</u> Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Cardio Vascular Disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>48 Hrs.</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ o. ft. _____ p. m. _____ Month _____ Day _____ Year <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>Oct. 6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct. 6, 1959</u> , and that death occurred at <u>4:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D.				ADDRESS (Street, city or town, state) <u>Forest Hill, Md.</u> DATE SIGNED <u>Oct. 7, 1959</u>			
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson M.D.</u>				Forest Hill, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 9, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friendship</u>		22d. LOCATION (City, town, or county) (State) <u>Fallston, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Kurtz</u>				ADDRESS <u>Garrettsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 13 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Krand</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11455

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11458

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wick Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harve de Grace		c. LENGTH OF STAY IN 1b 1 1/2 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton	
3. NAME OF DECEASED (Type or print) First Edward E Middle Tinch Last		4. DATE OF DEATH Month October 11 , Day 1959 Year 19	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH age 37 June 16, 1922
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Kent CO. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sylvester Tinch		14. MOTHER'S MAIDEN NAME Arrie Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-16-8572	
17. INFORMANT Florence Tinch		Address RFD Worton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture skull DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) auto accident auto object type			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) auto accident auto object type	
20c. TIME OF INJURY Month, Day, Year 6:00 PM 10-11-59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40		20f. (City or town) (County) (State) Harve de Grace Harford Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Gerald C Palmer		DATE SIGNED 10-12-59	
EXAMINER'S NAME (Type) Gerald C. Palmer, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/15/59	22c. NAME OF CEMETERY OR CREMATORY Coleman's Cem.	
22d. LOCATION (City, town, or county) (State) RFD Worton, Md.		23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Walley	
24a. REC'D BY REGISTRAR Oct 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

92-51-01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11459

CERTIFICATE OF DEATH

11456

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 132 Law Street		d. STREET ADDRESS 132 Law Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MYRTLE Middle GRACE Last TWEED		4. DATE OF DEATH Month October Day 15 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14, 1900
9. AGE (In years last birthday) 59 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Monroe Guhl		14. MOTHER'S MAIDEN NAME Emma Rutherford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. *** **	
17. INFORMANT Dorothy Nichols		Address 136 Law St. Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Insufficiency 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Obstructive Jaundice, Hepatitis DUE TO (c) Tumor (poss Cancer) of Pancreas		INTERVAL BETWEEN ONSET AND DEATH One week 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 14 , 19 59 , to Oct 15 , 19 59 , that I last saw the deceased alive on Oct 14 , 19 59 , and that death occurred at 9:30 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 114 W. Bel Air Ave. DATE SIGNED 10/16/59 ACTUAL SIGNATURE Andre Weiss M.D. PHYSICIAN'S NAME (Type) XXXXXXXXXX M.D. Aberdeen, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/18/59	
22c. NAME OF CEMETERY OR CREMATORY Spesutia Cemetery		22d. LOCATION (City, town, or county) (State) Perryman, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Tarring		24a. REC'D BY REGISTRAR OCT 20 '59	
24b. REGISTRAR'S SIGNATURE Charles S. Evans			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11475

CERTIFICATE OF DEATH

11457

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Fallston				c. LENGTH OF STAY IN 1b Entire life				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fallston, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rebecca Middle N. Last Watson				4. DATE OF DEATH Month October Day 16 Year 1959							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 3, 1878		9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Fallston, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William T. Watson				14. MOTHER'S MAIDEN NAME Elizabeth Amoss							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. -----		17. INFORMANT James O. Watson		Address Fallston, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chr. Cardio-vascular disease DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH 30 min. 10 yr.---			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct. _____, 19 49 , to Oct. 16 _____, 19 59 , that I last saw the deceased alive on Oct. 13 _____, 19 59 , and that death occurred at 6:40 a.m. _____, and that the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Willard P. Hudson M.D. 10/17/59											
ACTUAL SIGNATURE Willard P. Hudson M.D.											
PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D. Forest HILL, Md.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/18/1959		22c. NAME OF CEMETERY OR CREMATORY Friends Meeting				22d. LOCATION (City, town, or county) (State) Fallston Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Kurtz						ADDRESS Farmersville, Md.		24a. REC'D BY REGISTRAR DATE OCT 19 59		24b. REGISTRAR'S SIGNATURE Charles S. Kline	

CERTIFICATE OF DEATH

11175

NAME OF DECEASED JAMES H. HARRISON		AGE 45		SEX Male		RACE White		DATE OF DEATH October 10, 1929	
PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore		STATE Maryland		COUNTRY U.S.A.	
OCCUPATION None		EDUCATION None		RELIGION None		MARRIAGE None		SINGLE	
CAUSE OF DEATH Heart disease		MANNER OF DEATH Natural		PERIOD OF ILLNESS 10 days		DATE OF ONSET October 1, 1929		DATE OF EXAMINATION October 10, 1929	
SIGNATURE OF PHYSICIAN J. H. Harrison		SIGNATURE OF DECEASED J. H. Harrison		SIGNATURE OF WITNESS J. H. Harrison		SIGNATURE OF DECEASED J. H. Harrison		SIGNATURE OF WITNESS J. H. Harrison	

RECEIVED

11175